November 4, 2002

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-03-0208-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on ___ external review panel who is board certified in neurological surgery. ___ physician reviewer signed a statement certifying that no know conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 60 year-old male with a history of herniated nucleus pulposus at L4-5. This employee sustained an injury to his back on ___. His treatment to date has included physical therapy, analgesics and anti-inflammatory medication. He has also previously undergone a discectomy. He has requested authorization for a three level fusion with instrumentation.

Requested Services

Pedicle Screws and a 3 level 360 fusion.

Decision

The Carrier's denial of authorization and coverage for the requested surgery is upheld.

Rationale/Basis for Decision

___ physician reviewer indicated that there has been no clear identification of the pain generator in this case. Therefore, ___ physician reviewer concluded that there is no evidence to support the use of the requested surgical intervention with this injured employee. ___ physician reviewer explained that identification of a pain generator is needed to determine the appropriate treatment approach. ___ physician reviewer further indicated that the requested surgery is not medically necessary for treatment of the injured employee's condition at this time.

This decision is deemed to be a TWCC Decision and Order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10 (ten)** days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20 (twenty)** days of your receipt of this decision. (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed. (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings
Texas Workers' Compensation Commission
P.O. Box 40669
Austin, TX 78704-0012

A copy of this decision should be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute. (Commission Rule 133.308(t)(2)).

Sincerely,